SAMPLE POSITIVE NOTICE FOR BC PRENATAL PROGRAM

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES, Division of Health Care Financing
DEPARTMENT OF WORKFORCE DEVELOPMENT, Division of Workforce Solutions
HCF 16015 (Rev. 03/05)

NOD

POSITIVE NOTICE

Case Name	Case Number	Date
Jane Doe	1234567890	1-06-06

Address (City, State, Zip Code)
1234 Main St., Anywhere, Wisconsin, 12345

Child Care Assistance

☐ Your application for Child Care Assistance has been approved effective _____. Contact your worker to request a Child Care Authorization. You must have an authorization in order for your child care provider to be paid.

Wisconsin Works (W-2)

☐ (Circle one) Your application for W-2, Job Access Loan and/or Emergency Assistance has been approved effective _____. Your first payment will be $_____ for the month(s) of _____. After this, you will receive $_____ each month. Your first payment will be sent on or about _____ and you can expect delivery in one to three days from this date.

☐ Your W-2 payment will be increased to $_____ per month, effective _____ because _____.

FoodShare Wisconsin

☐ Your application for FoodShare benefits has been approved for the certification period beginning _____ and ending _____. You will soon receive FoodShare benefits in the amount of $_____ for the month(s) of _____. After this, you will receive $_____ in FoodShare benefits each month. To continue receiving FoodShare benefits, a review is required at the end of your certification period.

If you have never had a Wisconsin QUEST card, one will be mailed to you. If you no longer have your QUEST card, contact QUEST Customer Service Help Line.

☐ Your FoodShare benefits have been increased to $_____ effective _____ because _____.

Medicaid / BadgerCare

☒ Your application for Medicaid / BadgerCare has been approved for the period beginning 01-01-06 through 01-31-06 _____.

☒ Medicaid / BadgerCare has been approved for the following people Jane Doe, _____, _____, _____, _____, _____.

☒ Your Medicaid / BadgerCare "Forward" identification card will be mailed on or about 1-13-06. You can expect delivery in one to three days from this date.

☐ Your premium or liability has decreased to $_____ per month, effective _____ because _____.

If you do not agree with your Medicaid / BadgerCare, FoodShare benefits or Child Care Assistance decision, you can request a fair hearing. **Please see the enclosed for information about fair hearings.**

If you disagree with a W-2 decision, you can ask for a Fact Finding Review. You must ask for the review within 45 days from the date of the notice, or within 45 days from the effective date of the decision announced in this notice, whichever is later.

If you have questions please contact
County/tribal social or human service agency or W-2 agency

Distribution: Recipient – original Case file – copy